DOCUMENT RESUME

ED 326 768 CG 022 976

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TITLE Hurricane Hugo: Emergency Preparedness Planning and Response for Mental Health Services.
PUB DATE Aug 90
NOTE 44p.; Paper presented at the Annual Convention of the American Psychological Association (98th, Boston, MA, August 10-14, 1990).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Crisis Intervention; *Emergency Programs; Intervention; *Mental Health Programs; *Natural Disasters; Outreach Programs; Psychiatric Services; Rehabilitation; *Rescue; *State Action; State Aid; Statewide Planning; Weather
IDENTIFIERS *Hurricane Hugo; South Carolina; South Carolina State Department of Mental Health

ABSTRACT

This report describes how, in the aftermath of Hurricane Hugo, the South Carolina Department of Mental Health activated its Emergency Preparedness Plan to assist mental health centers and their staff in providing crisis counseling services to the general public. The first section explains the history and structure of the involvement by the Department in emergency preparedness planning since the late 1970s, and discusses the primary role of mental health personnel in providing crisis counseling services to victims of disasters. The second section describes the procedures following the initial hurricane alert, and the dissemination of instructions and plans to mental health center directors and staff throughout the state. The third section describes the mobilization procedures after the hurricane struck Charleston on September 22, 1989. The next three sections provide anecdotal examples of the interventions that clinical teams, known as Go Teams performed during the response and recovery phases of Hurricane Hugo as well as measures taken to help with long term recovery. The final section, "Looking at Hurricane Hugo from Inside Out," discusses and evaluates the experience and the emergency services from the local perspective of the Charleston Area Mental Health Center. The document concludes by listing 20 "lessons learned" from the catastrophe, the mobilization services, and the aftermath. (TE)

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HURRICANE HUGO:

EMERGENCY PREPAREDNESS PLANNING AND RESPONSE

FOR MENTAL HEALTH SERVICES

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PRESENTED AT THE 98th AMERICAN PSYCHOLOGICAL ASSOCIATION

ANNUAL CONVENTION, BOSTON, MASSACHUSETTS, AUGUST, 1990

ACKNOWLEDGEMENTS

The wise man in the storm prays God, not for safety from danger, but for deliverance from fear.

- Ralph Waldo Emerson

Flexible, responsive, creative, competent, magnificent, courageous, dedicated, caring, resilient, selfless...these adjectives only begin to describe the employees of the South Carolina Department of Mental Health and their response to Hurricane Hugo. Thank you will never be enough.

The authors also wish to express their gratitude to Brian Flynn, Ph.D., Chief, State Planning and Human Resource Development Branch of the National Institute of Mental Health. He has consistently provided guidance and support to the Department of Mental Heath throughout the Hurricane Hugo experience. His sense of humor, love of Barbecue, and proclivity for Waffle Houses has also endeared him to us.

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INTRODUCTION

The South Carolina Department of Mental Health has formally participated in Emergency Preparedness Planning since the late 1970's. Federal legislation required comprehensive State and local planning by mental health agencies in order to incorporate crisis counseling services into the total emergency or disaster response effort.

Research had demonstrated that victims of disasters experienced psychological trauma with predictable consequences. The resolution of such trauma was akin to the grief process. If left unresolved, post traumatic stress disorder and other mental health problems could result. Crisis counseling services could prevent this outcome for most individuals if these services were available immediately and for at least nine to twelve months after the event.

Because of stigma, these interventions were most successful if they were not associated with formal mental health services or obviously labeled as mental health services per se. Crisis counseling was most successful if woven into the relief and recovery efforts of others.

Emergency preparedness planning and response involves a variety of agencies and key actors on state and local levels. It is unique as each agency or participant has a set of federally defined guidelines to develop it's plan. The plan of each agency is developed independently of sister agencies or participants. The comprehensive plan and the

roles of the various participants are tested under only two conditions: 1) through training exercises or; 2) in actual man-made or natural disaster situations.

For the mental health portion of the plan, general planning must occur between the state mental health authority and the state agency assigned responsibility for emergency preparedness planning. Similar planning must occur between community mental health centers, county emergency preparedness agencies and psychiatric hospitals. At this level, the focus is on intra- and inter-organizational structure, call lists, location of personnel before, during and after the event, roles and responsibilities of personnel in impacted counties, as well as counties that provide recovery support services (e.g. supplemental fire protection, law enforcement personnel, etc.) to the impacted counties and host counties that provide sheltering and other services residents of impacted areas.

A second dimension in planning occurs internally at the state or central office level in each organization and within its local counterparts. For example, state and local mental health agencies, including the psychiatric hospitals, develop internal disaster plans. These plans focus on assigned responsibility for organizing and mobilizing a response, doing damage assessment, field work, caring for staff, their families and community victims, carrying out critical incident stress debriefings and calling on outside assistance

if the magnitude of the disaster is beyond the response capacity of the particular organizational entity.

A third dimension is planning between the state mental health authority and the local community mental health centers. This is particularly critical in major disasters as the state mental health authority has to decide if the magnitude of the disaster requires assistance from elsewhere in the mental health system. The staff of community mental health centers and hospitals in affected areas are often victims themselves and, consequently, are unable to respond effectively. The state mental health authority can, therefore, dispatch available resources of other community mental health centers and psychiatric hospitals. These additional resources are used to meet the operational needs of affected community mental health centers and psychiatric hospitals. These operational needs include responding to the crisis counseling needs of the public at large resulting from the disaster.

The devastation of Hurricane Hugo, even today, is incomprehensible to most people. Virtually half of the State was severely and directly affected; the other half was traumatized by the overwhelming response needs of the victims. Had the South Carolina Department of Mental Health not engaged in emergency preparedness planning or tested its' plan and response capacity during the tornadoes of 1984, and in subsequent training events, it would have been as immobilized as many other agencies were during the first week

to ten days after impact. Instead, the Department had a clinical staff of eighty (80) people in the field in less than thirty-six (36) hours assisting affected mental health centers and their staff and providing crisis counseling services to the general public.

The commentary that follows describes how that occurred and reflects the experiences of the South Carolina Department of Mental Health and its' employees from alert and mobilization on September 20, 1989, to the work currently being carried out by Hugo Outreach Support Teams (H.O.S.T. teams). It spans experiences from state level coordination activities to local response and recovery efforts.

HISTORY AND STRUCTURE

Involvement by the South Carolina Department of Mental Health in emergency preparedness planning began in the late 1970's. The State Commissioner of Mental Health appointed the Director of the Department's Office of Public Safety to work with the South Carolina State Emergency Preparedness Division to develop the required plan. The Office of Public Safety is made up of three units: 1) a uniformed patrol division; 2) an investigative division and; 3) a fire safety division. Employees of this office are commissioned law enforcement officers. Line officers have jurisdiction within the Department of Mental Health; the Director and his area chiefs have state wide jurisdiction.

Parallel to, but separate from this assignment, the Columbia Area Mental Health Center developed an interest in the psychological effects of trauma and began conferring with the county emergency preparedness director. Consequently, the mental health center became a routine participant in training exercises and real local emergencies like school bus accidents, tornados, etc.

As state level planning efforts moved forward, it became apparent that the primary role of mental health was the provision of crisis counseling services to victims of disasters. Given the fact that the staff of the Columbia Area Mental Health Center were experienced in doing this, a key member of their staff was appointed to serve as a clinical consultant and coordinator in the Department's emergency preparedness planning endeavors.

The Office of Public Safety continues to be administratively responsible for emergency preparedness planning and response. During a disaster, the Office of Public Safety has the delegated responsibility to activate the Department's disaster plan. It manages the logistical aspects of supply, manpower, staff security and access. The clinical coordinator manages orientation of clinical staff to the unique aspects of their role in a disaster, assures that there is a clinical presence at essential sites in the affected areas and manages the system's clinical response to the mental health needs of staff and the community at large. The combination of public safety and clinical expertise has

proven to be a critical one in successfully directing disaster response activities.

Organizationally, the South Carolina Department of Mental Health is unique among the fifty States. Both the inpatient facilities, of which there are nine, and community mental health center programs, of which there are seventeen, are operated by the State Department of Mental Health. Employees of the psychiatric hospitals and the community mental health centers are all state employees. This has enabled the Department to mandate statewide planning, require participation in exercises and commandeer resources more freely than if the community mental health centers were private non-profit agencies. Nevertheless, system wide planning and response is possible where community mental health centers operate as private non-profit agencies with contracts with the state mental health authority. Two key factors for successful planning and response, regardless how a mental health system may be organized, is sanction and leadership on the state level.

The South Carolina Department of Mental Health first activated its Emergency Preparedness Plan in March, 1984, when tornados swept the state resulting in a Presidential Disaster Declaration for about 8 counties. At that time, the clinical teams (also known as Go Teams) sent into affected areas came entirely from other community mental health centers. It was not until Hurricane Hugo that the resources of the psychiatric hospitals became part of the on going

response effort. These additional resources were essential because of the magnitude of need.

Also during the tornados, crisis counselors supported by Federal funds did not replace the Go Teams for almost three months. The Federal grant application process for immediate services funding for crisis counselors was not clear in 1984. During Hurricane Hugo, however, the Go Teams were replaced by crisis counselors beginning in the sixth week. The immediate services grant application process through the Federal Emergency Management Agency (FEMA) and the National Institute of Mental Health (NIMH) had improved significantly in the intervening five years.

Some initial depth of understanding about the mental health role in disaster response was achieved within the Department of Mental Health through the tornado experience. Also, the Department of Mental Health gained valuable experience applying for Federal financial assistance for crisis counseling. However, in the intervening years following the tornados, some of the momentum from the experience was lost. The Department had a change of State Commissioner's and a new management team. The experienced clinical coordinator retired in 1988 and was replaced by a novice who had helped write the crisis counseling grant for the tornados.

The year preceding Hugo had been spent trying to regain direction and momentum. During that year, State and local plans were reviewed and plan guidelines were rewritten in

coordination with the State Emergency Preparedness Division. Department of Mental Health staff began attending and participating in training events and exercises again. Work had also begun to apprise key management staff, many of whom were new to the Department, about the organizational structure and operational components required for the system to respond effectively to disasters.

September, 1989, marked the month in which the Department of Mental Health and the State Emergency Preparedness Division were to begin updating and upgrading local plans. Meetings between county mental health and emergency preparedness offices were to occur in order to strengthen these local plans. Also, the Department of Mental Health had planned to revise it's state plan to include calling on the clinical resources of the state hospitals.

The State Emergency Preparedness Division had begun to invite the Department of Mental Health to training events for its' county directors to discus the crisis counseling role in disasters. One such event took place in Florence, South Carolina on September 19, 1989. At that time, State and county Emergency Preparedness Directors were monitoring the progress of Hurricane Hugo and predicting a direct hit somewhere along the South Carolina coast for late Friday or early Saturday. Traveling back to Columbia, the Director of Public Safety and the clinical coordinator noted spotter planes from Ft. Bragg flying inland and news reports indicated Naval ships were being moved out to sea. They

decided to activate the Department's Emergency Preparedness Plan the next day.

ALERT

The State Commissioner was notified on Wednesday morning, September 20, 1989 that the Emergency Preparedness Plan was being activated. Instructions were faxed to the four community mental health centers located in the coastal areas. They were advised to make preparations to insure the safety of staff and families and to secure facilities, equipment, medical records and vehicles. Instructions were also given to strategically locate volunteer staff at shelters and county Emergency Operations Centers (EOC's), and to exchange phone numbers with the Mental Heath Emergency Operations Center (MHEOC) that was established in Columbia. Furthermore, mental health center directors were assured the Department would have support staff in the field attempting to make contact with them as soon as these staff could get into affected areas.

The remaining thirteen mental health centers and the nine inpatient facilities were alerted and asked to organize clinical Go Teams of two to four members who could travel with an hour's notice. The Department's management team was advised to be on standby to assist. All centers and hospitals received all communications that were sent out so that the entire system knew the instructions, plans and relevant phone numbers.

By late Wednesday, Hugo's landfall was predicted for late Friday somewhere between Jacksonville, Florida and Cape Hatteras, North Carolina. As Thursday dawned, the likelihood of Hugo's arrival on the South Carolina coast became more evident and the predicted landfall was moved up to early Friday morning. The Governor issued evacuation orders for the coast and the barrier islands.

Thursday was spent setting up the Mental Health Emergency Operations Center at the Public Safety Office. Go Teams, by facility and center, and phone numbers of key staff were posted. Linkage was established with the State Emergency Operations Center to receive regular reports during the course of the storm. Last minute instructions and reassurances were given and advance Go Teams were sent to some shelters to be immediately present after the storm.

By mid-day, Hugo was predicted to land at the Georgia - South Carolina border. By late afternoon, it was predicted to strike Charleston and move straight through the state. Within a brief period, the hurricane had begun to increase in wind velocity and speed and by three p.m. reached a category three. Sustained winds of 80 to 90 miles an hour for up to five hours were predicted for the capitol city, more than 100 miles inland. Staff manning the MHEOC went home for a couple of hours to take care of personal business returning at supper time prepared to remain there for the next 24 hours.

THE NIGHT OF HUGO

Hugo made landfall in Charleston at 12:01 am, Friday, September 22, 1989, with 135 mile per hour winds, traveling at 20 miles an hour. It had become a category four hurricane. Throughout the night, reports poured in of collapsing shelters, county emergency operations centers being evacuated, tornadoes, fires, exploding transformers, communications and power failures, roofs blowing off, and stranded rescue vehicles. The extent of fatalities and injuries was unknown. By four a.m., power and communications were down in about 24 counties in the State.

Throughout the night, the MHEOC coordinated the transporting of mattresses to the University of South Carolina coliseum, which had become a shelter for evacuees; setting up an infirmary for evacuees; and the provision of food and care to fifty-seven nursing home residents evacuated from Charleston. At four in the morning, the phones went down. Half the state had become shrouded in darkness and silence.

MOBILIZATION

By 10:30 a.m. on Friday, September 22, 1989, eight assessment teams comprised of a mental health clinician and a uniformed public safety officer were sent to eight community mental health service areas to locate center directors and

key staff, assess damage to facilities, and determine how much and what kind of help was needed. This information, theoretically, forms the basis for deciding how much and what kind of help to send into the affected areas.

The magnitude of the devastation reported by these teams was overwhelming. Power lines lay along the highways; trees criss crossed highways and cut through the roofs of houses; concrete blocks lay jumbled where houses and mobile homes once stood; acres of broken timber lay as though deliberately snapped in two. Three center directors could not get out of their homes because of tree damage. One of those lived 100 miles inland. With no power, stores could not keep food cold; cash registers, gas pumps and banking machines were inoperable; there were no street lights or water with which to drink or flush toilets.

Thousands who had evacuated awoke Friday morning to sunshine and warm breezes, ready to return home to assess the damage, only to learn that the highways were blocked, or bridges were out, or law enforcement had closed access for an indefinite period of time. Information from media sources was sporadic, inconsistent, and often unavailable because of tower damage from high winds. Only the phones seemed to work, most of the time. These conditions existed in over twenty-four of the State's forty-six counties.

Reports through the night made clear that the original plan for sending in a modest group of Go Teams would be wholly inadequate. The Department of Mental Health was faced

with tens of thousands of victims. Five of it's seventeen community mental health centers were impacted significantly, another four to a lesser degree.

The modest plan to call in a few Go Teams was abandoned and a call went to the unaffected community mental health centers and all the Department's psychiatric hospitals to send ALL available clinical staff. Staff were told to outfit themselves as if they were going to be engaging in primitive camping for four or five days. They were to bring all the food and other personal items of need with them, including water, sleeping bags, extra gas, etc. Self contained camping units were donated and became a precious resource. These clinical staff arrived in Columbia on Saturday morning at 9:00 a.m. for training and briefing.

As reports continued to come in, the scope of the Department's response broadened to include supplying relief to mental health staff who were themselves victims and making the Go Teams as self sufficient as possible. Consequently, teams were delayed going into the field as hospital and warehouse supplies were tapped to insure that Go Teams and local staff had food, water, ice, gasoline, candles, matches, cook stoves, cellular phones, diapers, hand wipes, formula, etc., etc., etc. This supply effort continued for over three weeks. It also included medication ranging from psychotropic medications for psychiatric patients to tetanus vaccines, antibiotics, insulin, etc., for general medical needs.

Operating principles were established for the Go Teams.

Members from the same facility/center went into affected areas together and came out together. This strategy was essential in maintaining a sense of connectedness and predictability among members during their time in the field. Also, while Go Teams were debriefed before going home, the problems of re-entry into normal living were mitigated by the fact that peers back home had a shared experience that those who had not been there would be unable to understand. They could support one another on an on going basis.

Another operating principle was that each Go Team had a leader to whom the members were responsible, but the team leader was responsible to the center director from the affected area. Community mental health center directors in the highly impacted areas were, however, confronted with a multitude of problems including significant damage and loss themselves. Consequently, the Go Team leaders, who in many instances were either former or present community mental health center directors and supervisors themselves, were able to provide the expertise and support to the directors which was critical to the functioning of the overall effort.

Relatively quickly, broad areas of responsibility emerged between the Go Teams and mental health center staff. A key element in recovery for affected mental health center staff was contacting their psychiatric patients and providing services to them. The Go Teams concentrated their efforts on responding to the crisis counseling needs of the community at large by working at shelters, relief and feeding sites, etc.

This division of responsibility has proved to be structurally sound in the long term as crisis counselors hired through the immediate services and long term FEMA/NIMH grants continue to serve the larger community.

Another principle was that of "taking care of our own." This meant taking care of the emotional and survival needs of mental health center staff as the first priority, whether victims or recovery workers. It took the rotation of the first team to learn this important lesson. The first team, after four full days in the field, virtually without break or rest, without power, water, or dry sleeping quarters, came out looking and acting no differently from the victims.

When the second group went in, it was with instructions that everyone, staff and Go Teams alike, were to work in shifts with equal time off for rest. Reporting to work regularly was critical for affected staff. It was part of restoring comfort through the structure of a normal routine in the midst of chaos. However, their ability to focus on their work for any lengthy period of time was limited. Predictably, the emotional energy of staff was divided between their work and their problems of obtaining food and water before the curfew came into effect, trying to determine whether insurance would cover the cost of repair or building anew, obtaining reliable contractors to begin the work, or whether they even had a home to return to as many of the islands were inaccessible.

By the time the second team went in, rotations of Go

Teams were planned for every three days with over lap between the team leaders. Debriefing was set up in the capitol city as well. Teams coming out were required to meet with debriefers before returning home. Debriefers helped members process their experiences, understand what some of their readjustment problems would consist of, grieve having to leave the area when so much help was needed, and express anger over the many frustrations that recovery entails.

A final principle was to maintain connectedness with the outside world. The MHEOC maintained 24 hour phone coverage for over three weeks. After the first week, few calls came in after 10:00 p.m. But, if the calls came, a mental health employee was there to answer.

This phone line became the nerve center of the whole operation. Requests for supplies, equipment and personnel were received and processed so that public safety officers, Go Teams and other staff who went into the field, went with their cars loaded. More importantly, staff and Go Team members alike would often call to "touch base." This provided reassurance that support and help were still there; that the larger outside world had not forgotten them; that soap, peanut butter, wet-wipes, etc., were on their way; that the next Go Team had just left town; that the first person they had talked to in the wake of the storm, whom they had never met, was real, was there and would visit and meet them in two days, etc., etc., etc. The emotional bond among everyone involved was palpable.

IN PURSUIT OF RECOVERY

The clinical Go Teams made up of Department of Mental Health employees from the psychiatric hospitals and community mental health centers throughout the state ranged in size from 80 people who went out on September 23, 1989, to 15 who went out the first week in November, the last week in which support from within the system was provided. These teams included nurses, physicians, psychologists, social workers, public safety officers,mental health specialists, pharmacists, activity therapists and maintenance workers. Medical personnel were especially critical in the early weeks of recovery. In latter weeks, the teams were more professionally balanced.

It is notable during this early response phase that Go Teams were instructed to not introduce themselves as mental health workers. They were also asked to not engage in traditional types of therapies. Rather, they were instructed to weave themselves into the relief and recovery activities of the larger community and to use these "natural environments" of shelters, food and relief lines, etc., as opportunities to work with people as they found them and to identify people at risk. The presence of mental health workers gradually became known to recovery personnel who, having seen the Go Teams calm distressed individuals, began requesting their assistance.

In some areas of the state, team leaders appointed one

second level coordinator to manage shelter coverage and one to manage the out reach workers. This delegation permitted the team leader to focus on setting priorities for service requests that were beginning to come in and negotiating solutions to unusual problems. Some examples of these problems included finding storage space for office furniture in damaged buildings; securing plywood to board up broken windows; finding sleeping space for Go Team members and staff, etc.

Initially, Go Teams supplemented the manpower of the shelters and traveled the rural areas locating people in need of assistance. This out reach in some rural areas included operating medical services until public health could take them over; working at relief centers sorting supplies, re-packing and delivering them; walking the beaches talking with people seeing their damaged homes for the first time or even trying to find where their homes had been; helping officials relocate people whose homes had been condemned; setting up supply distribution systems to areas and shelters not being served or overlooked by existing relief agencies; intervening with jailers, law enforcement and health and human service staff who were overwhelmed with requests for help and often were victims themselves.

When Disaster Assistance Centers (DAC's) opened, senior clinical staff were assigned to walk the lines with supplemental help from second year social work students to counsel and listen. Over time, these staff and students

assisted with taking applications and intervened when stressed DAC managers were unable to cope and were misdirecting the staff.

Meanwhile, requests started coming in from other agencies to debrief their staff, to train teachers and parents about how to help children cope, to work with stressed mayors and their staff in various communities and to advise about how to manage the stress reactions that were beginning to appear in recovery staff. Debriefing teams were developed and trained and a mechanism was established to uniformly respond to a variety of community requests.

After six weeks, the immediate services grant from the Federal Emergency Management Agency (FEMA) and the National Institute of Mental Health (NIMH) permitted the Department to begin replacing the Go Teams with newly hired crisis counselors. A vital casefinding linkage was made when the Department of Social Services and FEMA asked mental health to follow up on questionnaires that came back from applicants for assistance in which they indicated that they were still experiencing serious distress. Follow up became routine and intensified when damage lists from FEMA provided information about those who had experienced the most significant losses. Through a subsequent one year Federal grant, approximately 40 counselors have been hired to meet the long term needs of disaster victims.

Throughout the entire experience, the focus has been on the fact that the victims of Hugo are not psychiatric

patients who are mentally ill. Victims of disasters are normal people who are responding to overwhelming stress in normal and predictable ways. The task of the mental health professional was to help individuals grieve their experience and get back in touch with their fundamental strengths. This was accomplished by listening and supporting victims, affirming that their reactions were normal, and helping them assess what they can do or need to do to solve the problems that confronted them. An important element was to help them in connecting again with natural support systems and to use those systems constructively.

While a small percentage of the disaster victims needed more intensive and traditional mental health services, most responded to education, affirmation and support. It has been shown that people who experience serious mental health problems after a disaster are often those who suffered significant losses before the disaster and the disaster is the experience that tips the scale. These individuals are referred into the formal mental health system for services.

Some examples of the kinds of interventions that Go Teams performed during the response and recovery phases of Hurricane Hugo include the following anecdotes:

1. Two men from the second Go Team went to a beach area and talked informally with residents. They subsequently went to a relief center and helped re-pack donated food and supplies for distribution to island residents. While working at the relief

center, they met the mayor's wife of that community. They listened, offered support and indirectly educated her about what the community could expect to experience in their emotional recovery. On the last day, the mayor's wife learned these men were from mental health and was uncomfortable. However, she then began expressing her grief and concern for her community and the hope that the team replacing them would be as helpful.

2. A report came in that inmates at the jail were detoxing and getting out of control. Two workers were immediately sent to the jail only to learn that the inmates had suffered almost no deprivation as a result of Hugo. Jail personnel, however, were suffering many things. Curfews and working 12 hour shifts made it difficult for these men to pick up food and supplies for their families. One had a new infant; most had suffered significant damage to their homes; all had families who had to cope with the effects of the disaster alone while the bread winner was required to work. The mental health team first provided them with 17 bags of groceries they obtained from local relief centers. Then the team briefed them on where and how to obtain the full range of assistance for themselves and their families and helped them develop an internal structure to allow them to cover jail operations

while getting their basic needs met.

3. Two team members spent several days a week traveling the rural areas locating people who had been isolated from communication and transportation. They located a community of 30 people three weeks after the storm who had experienced no outside contact since the storm. Relief agencies were sent in to assist.

4. In one small community the local pharmacist and another community leader became regular contacts for Go Team members. These community leaders would advise the counselors of individuals in their community whom they were concerned about. For example, one women had many beautiful antiques that were taken into the yard so mud could be cleaned out of the house. The community leaders had observed that the woman was leaving the furniture in the yard in the rain and not moving it back inside. The counselors helped the woman move the furniture inside, dry it and in the course of those activities helped her to talk about her feelings and experiences.

5. On one of the islands, counselors worked at a feeding site. In the course of their work, they talked informally with victims, identifying those who might need additional assistance or who just needed to talk.

6. Social work students helped out at Disaster Application Centers. They operated day care areas and talked informally with families and children waiting in line to apply for assistance. Everyone had a Hugo story and these students listened with exceptional sensitivity.

7. Many training sessions were held for teachers, governmental employees, service providers and others who would be working with disaster victims as normal community operations resumed. While the focus was on how to help, these training events also served as debriefing sessions for "victim-caregivers." Indeed, they helped participants begin to understand their own feelings and reactions, what to expect in their own recovery and how to take care of themselves so that they could resume their normal lives and responsibilities.

The Go Teams, in the course of their community outreach, became very well known. Months later, others who had been in involved in recovery work will say, "You're from mental health? You people were everywhere during Hugo. I can't believe what y'all did." High visibility in non-traditional activities and places was crucial in supporting the success of the crisis counselors who followed the Go Teams. It has probably done more to challenge stigma than any planned initiative the Department of Mental Health could have undertaken.

LONG TERM RECOVERY

Hugo Outreach Support Teams (H.O.S.T teams), supported fully by the FEMA/NIMH grant program, began replacing the Go Teams in November, 1989. The work of these teams more closely reflects the counseling side of mental health disaster work. These teams spend 80 percent of their time in the field visiting victims, counseling them and helping them obtain assistance. They continue to provide debriefings to health and human service, school, law enforcement and other critical personnel. Through public service announcements and knowledge of the existence of the program by other providers, referrals continue at a steady rate. FEMA damage lists help to identify those at risk because of significant losses and these individuals are visited directly. Even agencies on the state level make referrals.

As noted, earlier, victims initially focused on meeting basic needs, clean up and repairing damage, which is predictable in a disaster. However, the degree of devastation extended this period of focused and purposeful activity into the holiday season, an unusually long period of time. Power, water and sewer services were disrupted as much as three weeks in some areas. The amount of debris from the storm that needed to be cleaned up and removed was almost incalculable. For example, on one island alone, it was estimated six weeks after the storm that 50,000 truck loads of debris had been hauled away and another 50,000 loads

remained. This did not include the debris that had been burned. At least 15 counties were faced with clean up problems of this magnitude. Structural damage that required makeshift as well as permanent clean up and repair also consumed people's attention. Consequently, crisis counseling focused on helping those still in shock to focus on concrete tasks, secure assistance and mobilize their personal resources.

The holidays delayed further the phase when anger and depression take over. During the holidays, people were grateful that they had survived. They focused on reclaiming as many of the holiday traditions as they could and took pride in the adaptations that were required. It was a time of renewed relief and giving. The problems in obtaining assistance, finding reliable contractors for repairs, getting insurance questions settled were held in abeyance.

In January, four months after the storm, depression and anger emerged. Debris was still everywhere. Roofs continued to leak. Insurance companies were still negotiating claims. Federal assistance did not meet perceived needs or expectations. Children were still in make shift school situations and many businesses still had not reopened so unemployment continued. Crisis counselors witnessed increases in substance abuse, a higher incidence of domestic violence and rape and increases in child abuse.

July, 1990, ten months later, depression continues to dominate with symptoms of post traumatic stress disorders

emerging. Crisis counseling continues to focus on helping people grieve, helping them understand their reactions are normal and educating them about what to do to take care of themselves and their family members.

It is July, 1990, and the hurricane season has begun. The Hugo Project is focusing on helping the public cope with renewed anxiety about the prospect that "it could happen again." A video tape was produced for school children to help them deal with this anxiety before beginning their summer vacations. Affected counties have been blanketed with public service announcements citing predictable feelings from the disaster. These prevention efforts help place in perspective the fear that it could happen again. Hugo Out Reach Project telephone numbers are widely publicized for individuals who are concerned about how they and their family members are feeling and coping.

It is July, 1990, and there are still people whose roofs have not yet been repaired, whose power has not been restored and who still require basic relief. The constant sounds of hammers and saws, the ever present piles of debris, the burning of trees, the tracks of bulldozers and dump trucks still invade the senses when traveling through the affected areas, particularly rural isolated ones. Total strangers still pull up to ravaged houses in vehicles with out-of-state license plates to replace and reshingle roofs, rebuild houses, remove debris. They might be Mennonites, or volunteers from Habitat for Humanity, or a church group from

another state who adopted a community. The vultures and rip-off artists are still present too, preying on ignorant, frightened, vulnerable people.

Devastation was so widespread that the Federal representative, on a grant monitoring visit six months after Hugo, commented that the state's level of recovery was where most disasters were at three months after impact. Emotional recovery has been hampered by the fact that victims often had only other victims to talk to and rely on while they also needed the same kind of support. It is difficult to listen when one urgently needs to talk.

Hugo impacted even the smallest aspects of life. As one mental health nurse from Charleston commented, " My husband needed an aspirin. All our married life we have kept the aspirin in the upstairs medicine cabinet. We didn't have an upstairs medicine cabinet anymore so neither of us knew where the aspirin was." Day after day, people are still confronted by the effects of Hugo. Often, people would say, "We can't get away from it. We see it (damage) going to work or going home. We deal with affected clients all day, then go home and deal with family, friends and neighbors. We spend all day negotiating repairs on the offices only to go home and argue with the contractors on the house. It never ends."

Still, perspective is powerful. In response to the standard question, " How are you doing?" one center director replied, " Really pretty good. The roof is still not

repaired, the floors are warped and buckling, the sheet rock is a mess, I've had to throw out all the appliances because of water damage, but we have heat and lights in one room of the house so we're really doing pretty good."

LOOKING AT HURRICANE HUGO FROM INSIDE OUT [1]

A discussion of emergency preparedness planning and response for the mental health needs of disaster victims would not be complete without exploring the experience from a local perspective. Charleston Area Mental Health Center provides comprehensive community mental health services to two counties. The city of Charleston is known for it's beauty, grace, charm and history dating from the Spanish explorations of the sixteenth century. It is surrounded by heavily populated barrier islands and beach areas. But beyond these areas, in the county, it is rural and poor. Neighboring Dorchester County has experienced significant growth as a suburban area for people commuting to Charleston, but it, too, is largely rural and poor.

As the probability grew of Hurricane Hugo making landfall in the city of Charleston, the mental health center began making preparations. On September 20, 1989, staff were instructed to evacuate in keeping with the Governor's Executive Order. For some, it meant leaving the area

[1] Zealburg, 1990.

altogether and for others it meant evacuating to shelters. The Emergency Psychiatry/Mobile Crisis Program of the Charleston Area Mental Health Center had been given responsibility for coordinating emergency mental health disaster services and supplied beeper numbers to evacuating staff to use on their return.

The program's clinical staff was thoroughly experienced in dealing with severe psychiatric emergencies, both in the emergency room and throughout the community. However, this was to be the staff's first experience in a major disaster.

The emergency services program manager coordinated with county emergency preparedness officials at the county Emergency Operations Center (EOC). The program director proceeded to a local school which had been converted to a shelter. The two automobiles assigned to the program were moved to higher ground and emergency psychopharmacologic drug boxes and cellular telephones were locked away in the shelter.

Zealberg (1990) describes his experience in a shelter the night of Hurricane Hugo:

> For those of us who stayed in the shelters, it appeared that our expertise in calming and supporting people was extremely useful. As the storm blew over, there was a strange and eerie silence within the shelter. The next morning one person said that she fantasized that the storm was the devil looking for victims. She said that she knew if she made any noise or if anyone in the room made any noise that he (the Devil) would know that we were within and he would break down the windows and doors and kill us. Numerous people used similar metaphor and said that having the volunteers continue to come around and reassure

them helped them through the night.

Six hours after the storm passed, the local response plan was activated by a phone call from the program director to the state mental health EOC. He reported that he and his family were safe, though they had to evacuate one shelter during the storm. He was advised to check on his home and take care of his family. He then reported to work and worked without a break for the next three weeks.

There were few psychiatric emergencies seen in the next two days. Most people were in a state of denial and shock, focusing on how glad they were to be alive. In the face of such massive destruction, material possessions lost their importance. By focusing on meeting basic needs, people seemed to manage the trauma better. In the process of attending to immediate needs, they felt they were "fortunate" compared to others. For example, people would say, " I have only lost my house, but the guy up the street lost his house, his boat and his car. I guess I'm really lucky." Many others felt survival guilt, especially those less heavily impacted by the storm. They often dealt with this by sharing their good fortune with others, thus diminishing any psychological disequilibrium.

Institutional medicine and psychiatric practice suddenly took on a different perspective and the primary need was to mobilize services within the community. Uniformly, people describe feeling a deep sadness related to the losses evident in the widespread destruction. Everywhere, it seemed, there

were displaced and homeless people in shock. The presence of uniformed National Guardsmen seemed to exaggerate feelings and perceptions. "Suddenly, the rubble that was in the streets, the searching through the debris, the militarily-clad men in the background with bayonets and automatic weapons was not a newsreel of another country, but was present in Charleston, South Carolina." (Zealberg, 1990).

The main office of the Charleston Area Mental Health Center became the team's "command post." Cellular phones and a gas powered generator allowed staff to organize a central communication and treatment site for mental health center clients and walk in emergencies. This local structure replicated the one at the state level and was essential in coordinating assistance from outside the Charleston area. As Zealberg (1990) explains:

> Perhaps one of the most critical components of the disaster service was the linkage with the central office of the South Carolina Department of Mental Health. The department had arranged for "Go Teams" to be formed from various Department of Mental Health agencies throughout the state including community mental health centers and inpatient units...Those teams came every 3 to 5 days and were completely prepared to do whatever was necessary to restore the mental health of those in need. After briefing, the "Go Teams" were quickly disbursed to various shelters around the town and were able to begin effectively dealing with people's mental health needs and all other needs as found appropriate.

Considering how complicated communication and understanding are under normal circumstances, the similarity between the purpose of the Go Teams from the state perspective, and the perception of the role of these teams

from the local perspective is remarkable. The Department of mental health and this local community mental health center had engaged in one local training exercise in the previous year - a repatriation exercise. There had been no real discussion of the principles of disaster response or the purpose of the teams until they arrived.

A fundamental principle emphasized in training "Go Teams" is that team members will be engaging in non-traditional interventions. Zealberg (1990) substantiates the importance of staff understanding this principle observing that "traditional roles were abandoned; student nurses helped coordinate emergency medical treatment and physicians would act as social workers or nurses as needed." Initially, there was little coordination of services. The absence of planning by other health and human service agencies on state and local levels contributed to this problem. Mental health staff found themselves dealing with many medical problems as there was no coordinated effort to bring acute medical care to the community. It took time for agencies to resume their operations and while that was occurring recovery personnel had to adopt unfamiliar roles and responsibilities. In general terms,

> One needs to be psychologically prepared and realize that in a disaster, everything changes. The real suddenly becomes unreal. The familiar, totally unfamiliar. The effect is extremely disorienting and anxiety provoking. Food, ice, batteries and generators were extremely scarce and water was undrinkable in many areas. It is important, therefore, for leaders in emergency preparedness to have provisions stocked for them and their families so that they can continue to

keep working at a rapid and efficient pace. (Zealberg, 1990

In addition to Go Teams, the Department of Mental Health sent teams of two uniformed public safety officers per twelve hour shift. One guarded the community mental health center's main office building because staff were staying for lack of accommodations in the city and medications were kept there, as well. Looting was a constant possibility. The other officer travelled with the mobile crisis team on calls made in the city. Normally, law enforcement is involved in the mobile emergency team's community interventions only if necessary. However, there were no street lights and conventional law enforcement was diverted to other activities.

Lack of resources in combination with overwhelming psychological trauma required expanded outreach capabilities. Emergency rooms were overcrowded with accidental injuries associated with clean up activities like chain saw accidents, cuts from glass and nails, fractures, etc. Wherever possible, people with mental health problems were treated in their homes, shelters, or sites other than hospital emergency rooms. The key agencies in the community knew the team and their work. Consequently, they were able to travel in restricted areas and function after curfew. Community awareness of the team also helped in obtaining assistance from relief centers. Such assistance met the basic needs of staff and their families allowing them to continue their work.

Scheduling crisis team workers became a critical issue. Staff returned to Charleston at different times following the storm and experienced different degrees of loss and damage. The program needed to be able to schedule staff for several days at a time, yet flexibility was important because of exhaustion and personal needs. Integration of Go Team members and crisis team members proved not only helpful, but a professionally challenging learning experience for staff from other facilities and community mental health centers.

The mobile crisis team discovered that the most important early interventions focused on supportive listening. Each person had a unique and often heroic story to tell. However, emergency psychiatric services increased in October following the hurricane. There was a thirty-one percent increase in persons seen over that month in 1988. Data is still being tabulated on this question. Nevertheless, there appeared to be a significant increase in suicidal depression.

The community mental health center's plan is cited as the most critical factor in its preparedness. Perhaps not so obvious was the integration of their efforts with state coordinated support until normal operations resumed. This is an example of how planning and the actual response between state and local mental health agencies is supposed to operate.

> In the wake of a natural disaster, people experience a numbness of thinking which is extremely disorienting. The high impact ratio of

> Hugo changed the cognitive-perceptual map of Charlestonians overnight. Because of this, it was difficult, if not almost impossible, to organize systems; the existence of an emergency plan was therefore critical. After emergency mental health services were set up and coordinated, administrative leadership was returned to those normally in charge. Normal institutional working operations were gradually re-introduced over a period of weeks, and the emergency service gradually and naturally returned to it primary focus. (Zealberg, 1990)

While debriefing and trauma counseling were major initiatives from the state level, it was insufficient to meet the needs expressed by this center's staff. The focus was more on the Go Teams. Affected community mental health centers often did not receive debriefing or trauma counseling until much later in the recovery phase.

In summary, the view represented by Zealberg (1990) provides striking support for many of the guiding principles that have defined the mental health role in disaster response. It also validates the early intervention strategies that have emerged and supports the importance of relating to victims as people experiencing normal and predictable emotional reactions. It also reinforces the observation by state level staff that response and recovery personnel are often neglected in receiving emotional assistance during and following disasters.

LESSONS LEARNED

1. Emergency preparedness planning and staff participation

in training exercises help staff gain a conceptual understanding of response requirements. While planning and training will never be sufficient to fully prepare people to cope with disasters the magnitude of Hugo, staff will move into response and recovery activities faster, with more flexibility and with more realistic expectations.

2. Predictable aspects of disaster response that require the management of information to make decisions or is routine information that participants need about their roles should be defined as much as possible through hand outs, guidelines, protocols and check lists.
3. The most vulnerable group for post traumatic stress disorders and long term emotional problems are the people actively involved in response and recovery efforts. This is especially true for those in leadership positions and those who are victim - caregivers. Debriefing and trauma counseling should be mandated for these individuals.
4. Disasters are seductive. Once people become involved they do not want to leave, or take a break, or go home. They often reach a point where they have no idea how tired or irritable they are. Pre-disaster training should include the understanding that involved staff must have the prerogative to <u>order</u> peers, subordinates and supervisors to rest or go home.
5. Schools are one of the most effective institutions for educating the public. Coloring books for children about

tornados, floods, hurricanes and other disasters should be on hand; the agency should have mechanisms to print and distribute large supplies of these. They educate children, teachers and parents.

6. Mental health agencies have to suspend the rules in order to respond successfully to disasters. Staff should have permission to function outside of their traditional or normally assigned responsibilities. Provisions should be in place to enable workers at all levels in the response effort to procure supplies, equipment and services immediately. Organizational boundaries should become fluid to respond to critical needs.
7. Daily briefings among staff coordinating the response is essential in maintaining momentum and shifting focus as the recovery effort matures. Individual talents emerge in a crisis that are otherwise unknown. These talents often prove crucial in a successful response.
8. A training curriculum and strategy should be in place so that staff going into the field in the initial response phase are prepared for the fact that almost nothing they do will be familiar or traditional; that victims are normal people responding in predictable ways to overwhelming stress. Their job is not to define what they encounter with the public as mental or psychiatric illness.
9. Mental health agencies should be prepared to provide purely medical services in early response efforts,

especially in rural areas. Early response teams should include physicians, nurses, and pharmacists. They should be prepared to manage such health problems as inoculation against tetanus and typhoid, injuries requiring suturing, births, infection, and chronic illnesses requiring daily medication such as diabetes and mental disorders.

10. Current inventories of supplies and equipment and their location is essential. Cellular phones are critical in coordinating the activities of Go Teams who may be in the field for several days. Generators, chain saws and building supplies are necessary in making service sites useable.

11. Uniformed security is essential to gain rapid access into affected areas. The uniformed public safety staff provided security in shelters, escorted outreach workers in high crime areas, patrolled office sites when the latter had to be used by staff as sleeping quarters and acted as guards in transporting supplies and equipment. Staff could not have worked in safety without these personnel.

12. Personnel responding to a major disaster should expect to experience survivor guilt. To witness the losses of one's colleagues and to understand what they live with day in and day out in the aftermath is very unsettling.

13. Personnel coordinating disaster response activities can expect that people on the periphery will perceive the scene as chaotic, confusing and without purpose. Active

personnel perceive themselves as working at such a fast pace they do not have time to bring others up-to-date; fringe personnel are so overwhelmed by the pace they perceive it as unorganized.

14. Centralized communication facilities on the state and local levels are essential so that needs can be determined and resources distributed in a coordinated and efficient way.
15. Early visibility and intervention; rapid dissemination of information to the public and assertive outreach are key actions to minimize the psychological effects of disaster.
16. Mental health workers in shelters before impact is extremely helpful to evacuees and very reassuring to shelter managers.
17. Interactive teams on all organizational levels are critical to maintain an appropriate response. As individual staff become overwhelmed by the scope of the disaster or the multiplicity of need, there is a tendency to try to redefine the boundaries of the disaster or the organization's role to make the seemingly impossible, possible. The team counteracts this.
18. Go Team staff are viewed as the "guts and glory" group. They receive well deserved praise and attention. Staff who remain back home, covering the jobs team members left, need equal recognition. They too contribute to disaster recovery operations.

19. People engaged in response and recovery activities make mistakes. The pace, drama, tension and anxiety make it inevitable. Forgiveness and humor are essential.

20. No one believes a major disaster will happen to them. Denial is a continuous challenge in trying to plan, train or prepare organizations and individuals for disasters.

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